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ABSTRACT

Bulimia, an eating disorder characterized by binge eating followed by purging and intense feelings of guilt and failure, is increasing among young women. The eating behavior is only a symptom of more complex underlying problems such as feelings of inadequacy, social isolation, depression, rigid thinking, self-defeating thoughts, and perfectionism. In order to investigate the effects of group therapy on bulimic women, 14 bulimic college students participated in one of two weekly counseling groups. The first group met for two semesters, while the second group met for the second semester only. The counseling sessions were led by a group facilitator who guided discussion toward dealing with the intensity that drives the eating behavior rather than dwelling on eating habits. Individual counseling was also available to all participants, and especially for those struggling with serious depression. Two recurrent themes in the group sessions were that of becoming the "responsible child" in the family at an early age and the feeling of having been let down by parents at a critical time. Successful therapeutic interventions included recognizing rigid thinking patterns, giving up control to get control, alternative coping skills to reduce tension, and recognizing and avoiding stress patterns that develop with premature "recovery". Based on data collected on the Eating Attitudes Test (EAT) and self-reports, most members of the longer running group reduced their binge eating behavior and changed their eating attitudes. In the shorter running group the number of binges per week decreased but the EAT scores remained constant. (BL)

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Bulimia: A model for group therapy

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Running head: BULIMIA: A MODEL FOR GROUP THERAPY

Abstract

This article presents an overview of the problem of bulimia and suggests a model for group intervention. Issues frequently encountered and suggestions for counseling intervention are discussed.

Many recent issues of popular magazines and episodes of television programs have had sections devoted to the topic of bulimia. More and more, the public is becoming aware of the devestating effect this eating disorder has on the young women by whom it is practiced. The fact that the individuals most likely to have an eating disorder are bright, achieving young women is confusing to many. It is difficult to understand the self-distructive habits adopted by women who seem to have everything going for them.

At the same time that this awareness is developing in the public, the individuals suffering from bulimia are getting the message that they are not alone in their misery and that help may be available to them. As a result, college counseling centers and mental health agencies are seeing a large increase in the number of bulimic clients seeking therapy.

BACKGROUND

Bulimia is an eating disorder primarily found in young women. A few male cases have been reported (Boskind-Lodahl, 1976; Russell, 1979) however, these cases represent less than 5% of the total cases reported in the literature (Mitchell & Pyle, 1982). Bulimia is characterized by binge eating followed by intense feelings of guilt and failure. The primary feature of binge eating is defined as a compulsive consumption of large amounts of food, frequently high

caloric carbohydrates, accompanied by a feeling of being out of control of the amount ingested. The binge usually takes place when the individual is alone and may last several hours (Garfinkel & Garner, 1982). Individuals vary widely as to the method of ridding themselves of the excessive calories consumed in the binges. The most frequently practiced method is self-induced vomiting, however, laxative abuse, fasting, excessive exercise, and amphetamine or diuretic abuse may be used. Frequently, individuals use more than one of these methods to compensate for the binge. Sometimes, the binge is followed by sleep to avoid the discomfort of the large amount of food in the stomach. These individuals may gain a considerable amount of weight over a short period of time. Occasionally, a pattern develops of chewing and spitting out of large quantities of food.

Originally, interest in bulimia developed out of the realization by several investigators, that a substantial number of anorexic patients being treated practiced binge eating and purging. In three reports of patients hospitalized for anorexia, over 40% were found to have bulimic symptoms (Casper, Eckert, Halmi, Goldberg, & Davis, 1980; Garfinkel, 1981; Beaumont, George, & Smart, 1976). Hsu, Crisp, & Harding (1979) did a follow-up of patients with anorexia nervosa and found that 44% of them had bulimia. It has been concluded that, when bulimia is associated with anorexia, it is an indicator of poor prognosis (Pyle, Mitchell, & Eckert, 1981; Garfinkel, Moldofsky, & Garner, 1980). This may be related to the

duration of the illness. That is, the individual may start out as an anorexic and develop the binge-purge cycle as the illness becomes chronic (Garfinkel & Garner, 1982).

In a sample of hospitalized anorexics, Garfinkel and Garner (1982) found differences between bulimic anorexics and restrictive anorexics. Those with symptoms of bulimia had a greater tendency to be premorbidly obese and had weight, food and impulse related problems during the illness. They had a considerably larger than normal incidence of maternal obesity. Bulimic anorexics were more likely to be sexually active than restricters, but reported rarely enjoying sex and having feelings of being used sexually. Their moods are labile with depression common. A history of suicide attempts was not unusual (Garfinkel, 1981; Strober, 1980).

Using the California Personality Inventory, Strober (1980) demonstrated that bingers have less adequate self-control than restricters, yet are more social, more psychologically minded and have a greater degree of adaptability and flexability in their thinking and social behavior.

Other investigators have focused their attention on bulimic women who were not among those hospitalized for anorexia. Largely, this group consists of individuals who practice binging and purging but who maintain normal weight. In a survey, Halmi, Falk, & Schwartz (1981) found that 13% of the "normal college population" experienced all the major symptoms of bulima as

stated in DSM III. Of this bulimic population, 87% were female. This constituted 19% of the female population surveyed on that campus.

In a 1976 article, Boskind-Lodahl approached the concept of bulimia from a feminist perspective. She describes bulimic women as having learned a passive, accomodating approach to life from their parents and the culture. She sees the bulimic as a victim of society's heritage of sexual inequality, both fearing rejection in sex and feeling not good enough to please a man. The bulimic woman lacks a sense of personal power or self-worth.

There are several physical problems that may result from the binge-purge cycle. The women may complain of having a sore throat or stomach ache from vomiting. They may also have sores around the mouth or cracked lips from the gastric acid contact. Dental problems can result from the erosion of tooth enamal and excessive consumption of sweets (Pyle et al., 1981; Hurst, Lacey, & Crisp, 1977). Because of the loss of body fluids from vomiting, laxative abuse, and occasionally, diuretics, the bulimic individual may suffer a depletion of potassium. This hypokalemia may result in muscle weakness and heart arrhythmias that, in extreme cases, may become life threatening (Garfinkel & Garner, 1982).

GROUP MEMBERS

The subjects this article is based on consists of fourteen women seeking treatment for bulimia at the University of Missouri

Counseling Center. All were within normal body weight range or slightly above. None had been treated for anorexia nervosa, although three gave histories of eating behavior that might have been considered anorexic, none had been hospitalized or treated for weight loss. All met the criteria for bulimia as stated by DSM III.

The subjects were given the Eating Attitudes Test as a part of the screening for the group. The Eating Attitudes Test was originally developed for use with anorexia nervosa patients by Garner and Garfinkel (1979). They reported a mean score of 15.6 for normal felmale control subjects - primarily university students. The anorexia nervosa sample scored a mean of 58.9. The subjects for this report scored a mean of 39.2, with a range from 29 to 55. Garner and Garfinkel recommend a cut off score of 30 to eliminate false negatives for anorexia nervosa. It is clear that the Eating Attitudes Test can be used to distinguish bulimics who are not anorexic from the general college poupulation.

The group members were attractive, well groomed women who were better than average students (Mean Grade Point Average=3.2). As is frequently reported of women with eating problems, the women came from families where the father was a professional who earned a good living. Typical occupations of the fathers were physician, engineer, accountant, and several owned their own business. The women came from larger than average families, with a mean of 5.5

children and a range of 1 to 13. Only five of the 15 were the oldest child including 1 only child. Only one member experienced divorce in her family while growing up. Another lost a parent through death as a child, but the remaining grew up in intact families where few of the mothers were employed outside the home.

Each person indicating interest in participating in the group was seen individually by the counselor prior to admission to the group. This is important for several reasons. A number of women who were seeking help did not fit the criterion for bulimia. It is essential to have individuals describe their eating behavior in detail, especially when diagnostic criteria such as vomiting and laxative abuse is not present. An overeater will typically describe frequent snacking and low impulse control such as, "I ate a whole bag of potato chips last night". When a bulimic describes a binge, it is usually something like, "I ate two dozen doughnuts, a couple of candy bars, a bowl of cereal and some cookies." They also talk about not tasting the food and being unaware of feelings of satiation or fullness until they reach the point where they are acutely uncomfortable. It is not unusual for bulimics to under report the severity of their problem when first evaluated (Mitchell, Pyle, & Eckert, 1981). It is important to ask if they purge during a binge, i.e., eat, vomit, come back and eat more and vomit again. This cycle may repeat several times but often is reported as a single binge by the client.

Another important purpose of the screening for the group is to check for mood swings and depression. Serveral reports indicate a high incidence of depressive symptoms in patients with bulimia (Russell, 1979; Plye et al., 1981). Russell reported 11 out of 30 patients hospitalized for bulimic anorexia had a history of suicide attempts. Pyle et al. reported an elevation of the depression scale (mean of 74.6) on the MMPI's of 30 outpatients. It was not unusual to find serious depression in the women screened for the group. In such cases, these women were seen individually until the group could begin. For some, the depression was significant enough to seek psychiatric consultation.

A number of the women did not openly seek counseling for bulimia. Several presented with a request for help with losing weight, although most of them appeared to be within a generally acceptable weight range. When questioned about their eating behavior, it became apparent that they were bulimic. One individual, who did not purge, had gained over 30 lbs. in a 2 month period. This pattern of rapid weight gain was seen in two women who had recently been dropped as members of university athletic teams. It had been a common practice for the team to have a "group gorge" after the rigorous training sessions. While still on the team, the physical exertion had allowed the women to consume enormous amounts of food without gaining weight. When they were dropped from the team, the binge eating pattern remained and

resulted in rapid weight gain. This was exacerbated by the loss of the social support system of the teammates and the withdrawl from any form of regular exercise.

GROUP FORMAT

The groups met once weekly with an unstructured format. Confidentiality was established as a norm in the first session. The group facilitator stated her role as that of a guide, rather that a group leader. It also was established that food and eating behavior was not to be the major topic of discussion in the group. There is a tendency for participants to want to dwell on their eating habits. Some of this is good to establish commonality within the group, however, the topic may be used to avoid discussing more emotional areas. When the interaction turns to telling "war stories", the counselor needs to direct the flow of the interaction back to more personal issues. The major thrust of the therapy must be directed toward dealing with the intensity that drives the eating behavior. The individuals must become aware of the build up of pressure that leads to a binge and begin to cope with that portion of the cycle.

Several members of the group were also seen as individual clients by counselors other than the group facilitator. This was necessary, especially, for those struggling with more serious levels of depression. For the remaining individuals, there was a

"therapist on demand" offer made. The group facilitator felt it would be detrimental to the group to see some members and not others as individual clients for extended periods, however, she was willing to see them for occasional sessions between group meetings. If it became apparent that extensive individual work was needed, the client was referred to another counselor and continued in the group.

The offer of the opportunity for individual work was important. The group sessions were time limited and often material of very heavy impact was discussed. With seven or eight people in a group, it was not unusual for someone to feel "unfinished" when the session ended. Feelings of anger or depression sometimes became intense between group sessions and needed to be dealt with before the next group meeting.

RESULTS

One of the two groups was started in the fall and allowed to run through the following semester. The other group was begun at the beginning of the second semester, because of increased demand, and was terminated at the end of that semester because of summer vacation.

Insert Table 1 about here

As can be seen in table 1, most of the members of the longer running group achieved considerable reduction of their binge eating behavior. The two members who did not significantly reduce their binging, both had histories suggestive of anorexia. This tends to follow the concept of a poor prognosis when bulimia is connected with anorexia (Pyle et al., 1981; Garfinkel et al., 1980). These members were also the least likely to take advantage of the therapist on demand offer and refused the offer to see another therapist individually.

In this group, the scores on the Eating Attitudes Test seem to reflect the decrease in the number of binges per week. Three had given up binging and purging entirely. Two reported binging lesser quantities and a reduction of purging to occasionally or not at all.

In the shorter running group, the number of binges per week had decreased in most cases but the EAT scores had not declined. This is similar to the point at which members of the other group were, at the end of one semester.

COMMON BACKGROUND ISSUES

In taking a history and as the group progressed, it became apparent that there were themes that repeated in various forms throughout the backgrounds of the women. The two that stood out most clearly were that of the woman becoming the "responsible

child" in the family at an early age, and the feeling of having been let down by their parents at a crucial time in their childhood.

The Responsible Child

Women with bulimia often have had to take on responsibility for themselves and sometimes others in the family at a younger age than most children. This generally is due to a mother or father not fulfilling the parental role for some reason. "My mother developed a chronic disease when I was twelve. I took over managing the home and she became an invalid." "My father committed suicide when I was nine and I was told by the minister and friends that I needed to be grown up and help Mom and take care of my brother."

Sometimes the "responsible child" is acting as a buffer between abusive parents and younger children. "I never had time to be a child, myself. As long as I can remember, I was taking care of my brothers and sisters. I drew my father's attention away from them when he was angry."

The role of "responsible child" may develop out of an attempt to compensate parents for difficulties caused by another sibling. "My sister caused my parents so much heartache. She was wild and rebellious and I couldn't bear hurting them the way she did."

Sometimes, the responsibility comes from having to be more grown-up than the individual is ready to be. "When I was

hospitalized for six months as an eight year old, I was told to be brave and not to upset everyone by crying or being frightened." "I got my period in the forth grade. I wasn't ready to be that grown up yet."

My Parents Weren't There for Me

A common theme running through these client's lives is a feeling of having been abandoned or not attended to by parents at a critical time as a child. "I was constantly harrassed and beaten up on by my brothers. My parents acted like it wasn't happening." "The boys were given special treatment in our family. They always came first. My mother has realized this now and is trying to make it up to my sister and me but it really is too late My sister is bulimic too." "After my dad died, my mother never talked about him. It was like he never existed. If I asked about him, she answered as briefly as possible and changed the subject." "I ran away from home when I was in high school. When I came back, nothing was ever discussed. It was like I'd never been gone."

This feeling of not being treated as a real person is graphically described by a young woman when she said, "I felt like I was screaming for help in a room full of deaf people."

THERAPEUTIC INTERVENTIONS

It Doesn't Have to be That Way

One of the concepts repeatedly emphasized by the facilitator

was that "It doesn't have to be that way." This was used to confront and challange the rigid thinking characteristic of the bulimic clients. Initially, what many of them would like in therapy is to be told the "right way" to approach their life. They turn to the group facilitator to tell them what to do. The counselor must be careful of the hazzards of this role. For example, if the counselor suggests exercise to a sedentary client as an aid in overcoming depression and as a coping skill for stress, the bulimic will frequently turn this into a rigid ritual. "I decided to exercise every day in December for at least 20 minutes." No exceptions are allowed and the individual has set herself up for failure. What was intended as a stress reliever has become an additional stressor. This is frustrating to both client and counselor.

Some of the bulimics that wish to lose weight approach dieting in the same rigid fashion. They plan to eat the exact same menu every day at precisely the same time. If circumstances cause deviation from this plan, they have failed again. This "failure" often leads to self-depricating thoughts which trigger a binge. This further confirms their "loser" status and may lead to depression and feelings of hopelessness.

When the clients start to express this sort of either/or, black or white type of thinking, it is important to challange these polarities with "it doesn't have to be that way." The

generation of alternatives and less rigid type of thinking is essential to recovery. Eventually, individuals become aware of the self-defeating nature of their rigid standards. One of the group members made a sign for her desk that said, "There is a middle!"

It is important to challange the negative self-talk that accompanies each "failure". Part of this can be done by reframing the behavior as "intended to help". A phrase that can relieve some of the guilt associated with the eating is, "You may need to continue to binge a while longer until you can learn some other coping skills." This not only gives "permission" for the behavior but implies a time limited quality to the need for it. A major step toward recovery seems to take place when the woman can see a binge as an isolated incident rather than catastrophyzing that she is completely without control and is doomed to repeat the pattern for the rest of her life.

Giving Up Control to Get Control

A concept that was very useful in the group was that of giving up control to get control. When this idea is first brought up, it is often very threatening. The conselor must be careful not to say "lose control" as that is the thing most feared by bulimic clients. It is this intense need to tightly control their world that often is driving the eating behavior. It is only by relaxing their frantic grip on events and emotions that bulimics

can gain some feeling of being in control of their lives. Only after that is reached can the eating behavior diminish and fade away.

When explaining this concept, it is helpful to use a metaphor. "If you were to try to hold a handful of sand in your palm by gripping it as tightly as you could, you would lose most of it through your fingers. If, instead, you held it gently in your cupped palm, you would be able to keep most of it with little effort."

The truth of this phemenon is illustrated frequently in the therapy sessions. "I wanted to strangle myself sometimes, I wanted to be in control so bad. When I fought the hardest for control is when it was the worst."

Coping Skills

It has been noted that an important component of compulsive eating is its tension reducing qualities. For compulsive eaters, eating is the major coping skill for dealing with unpleasant affect, especially anxiety and depression (Casper et al., 1980; Ondercin, 1979). As with any clients who are depressed, it is therapeutic to help them to develop alternative coping skills such as the relaxation response and habits of moderate exercise. Cognitive interventions such as thought stopping and contesting of irrational beliefs and demands also proves helpful.

One of the major aids in reducing the intensity of anxious feelings was the development of friendships among group members. Many of the women had found it difficult to develop close friendships because of the problem maintaining secrecy about their eating habits. "Whenever someone starts to get too close to me I pull away. I'm afraid they will find out about my eating and reject me so I reject them first." The commonality of the group allowed this barrier to be set aside. Members exchanged phone numbers and encouraged each other to call when they felt depressed. At first, individuals only called when they were feeling good, but, gradually they allowed themselves to call when they were feeling the overwhelming loneliness and depression that often preceeds a binge. Several lasting close friendships developed among group members and socialization outside the group became common.

The groups did a lot of encouraging each other to allow themselves pleasure in ways other than eating. The feelings of inadequacy, failure and lack of self-worth associated with the eating disorder tend to cause individuals to overlook sources of good feelings or to feel unworthy of allowing themselves the luxury of such activities.

It is important for the counselor to realize that improved feelings of self-worth and well-being come before the cessation of the binge eating rather than the reverse. Indeed, it is not

unusual to hear, "I am feeling so much better about myself, why am I still binging?" There is often a lag period where the habit strength of the eating behavior is still stronger than the other coping skills.

It is important to encourage the bulimic client to begin eating normal amounts of food again at the next meal following a binge. There is a strong tendency, especially if she has refrained from purging, to fast or severely restrict calories to relieve the guilty feelings and avoid possible weight gain. This pattern promotes the buildup of the intensity that triggers another binge. Resumption of normal eating helps to break this cycle by signaling the end of the episode.

Premature "Recovery"

As the bulimic client begins to learn new coping skills and uses eating less as a solution to stress, they start to see themselves as having "recovered". It is extremely important not to terminate prematurely with these clients at this point. It is often, just as the client declares herself cured, that the bulimia returns with increased intensity.

The most common reason for the relapse, is escalated demands they place upon themselves. "Now that I was no longer binging, I suddenly felt like I had to make all the decisions I had put off until I got rid of my eating problems. My career, my relationship

with my boyfriend, my entire future had to be determined right now. I panicked and started binging again."

Another problem seems to be, that once they see themselves as "cured" they feel that they should no longer need to ask for help. "I felt like I couldn't call anyone in the group when I got upset. I would be letting you down. Finally, it got so bad, I binged."

For some, the self destructive pattern has gone on so long, it is frightening to let go of it. "If I let go of the pain, make that change, will I be who I am still? I'm scared. I come up to a point of being almost there and I blow it. That's what I am doing now. I am touching palm to palm with who I am and I am running away."

With others, significant relationships may encourage maintainence of symptoms. "I am afraid to get healthy. The only time my mother pays attention to me is when I am sick. Even so, each time I have to get sicker or more depressed to get her to notice."

SUMMARY

Although the numbers in this report are not large, it can be tentatively concluded that bulimia can be treated by a group therapy approach in a college counseling center. This is clearly a deep seated problem that does not respond to short term intervention. The treatment is likely to be a long and involved

process. The eating behavior is actually only a symptom of fairly complex underlying problems. Feelings of inadequacy, social isolation and depression must be dealt with. There needs to be an awareness of potential suicidal tendencies. Rigid thinking, self-defeating thoughts, high needs for control and perfectionism must be challanged. Further research needs to be done to help guide counselors facing the increasing demand for out-patient treatment for eating disorders in our college and university counseling centers.

Table 1

Number of Binges per Week and Eating Attitudes Test Scores Pre and Post Group Treatment

Subject	Pre-group		Semester 1		Semester 2	
Group 1	Binges	EAT	Binges	EAT	Binges	EAT
A.	3-4	42	1-2	26	1-2[a]	15
B.	2-3	43	0.5	15	0	8
C.	1-4	43	0	13	0	7
D.	2	29	0	7	0	
E.	1-4	41	3	22	2[a]	8
F.[b]	28-40	30	28-30	30	22	16
G.[b]	14-28	42	21	34	21-28	37
Group 2						
H.	2-3	42	2-3	36		
I.	7-14	41	3	25		
J.	7	29	1	37		
K.[b]	5	36	0.5	35		
L.	14	55	3-5	15		
M.	2-3	44	2	30		
N.	3	31	0	14		

[a]These group members were those that gave a history suggesting anorexic weight loss while adolescents.

[b]Reduced amount in the binge. Purging occasionally or not at all.

Hsu, L. K. G., Crisp, A. H., & Harding, B. (1979). Outcome of anorexia nervosa. Lancet, 1, 61-65.

Hurst, P. S., Lacey, J. H., & Crisp, A. H. (1977). Teeth, vomiting and diet: A study of the dental characteristics of seventeen anorexia nervosa patients. Postgraduate Medicine Journal, 53, 298-305.

Mitchell, J. E., & Pyle, R. L. (1982). The bulimic syndrome in normal weight individuals: A review. International Journal of Eating Disorders, 1, 61-73

Mitchell, J. E., Pyle, R. L., & Eckert, E. D. (1981). Frequency and duration of binge-eating episodes in patients with bulimia. American Journal of Psychiatry, 138, 835-836.

Ondercin, P. A. (1979). Compulsive eating in college women. Journal of College Student Personnel, 20, 153-157.

Pyle, R. L., Mitchell, J. E., & Eckert, E. D. (1981). Bulimia: A report of 34 cases. Journal of Clinical Psychiatry, 42, 60-64.

Russel, G. F. M. (1979). Bulimia nervosa: An ominous variant of anorexia nervosa. Psychological Medicine, 9, 429-448.

Strober, M. (1980). Personality and symptomalogical features in young, nonchronic anorexia nervosa patients. Journal of Psychosomatic Research, 24, 353-359.

References

Beaumont, P. J. V., George, G. C. W., & Smart, D. E. (1976). 'Dieters' and 'vomiters and purgers' in anorexia nervosa. Psychological Medicine, 6, 617-622.

Boskind-Lodahl, M. (1976). Cinderella's stepsisters: A feminist perspective on anorexia nervosa and bulimia. Signs: Journal of Women in Culture and Society, 2, 342-356.

Casper, R. C., Eckert, E. D., Halmi, K. A., Goldberg, S. C., & Davis, J. M. (1980). Bulimia. Its incidence and clinical importance in patients with anorexia nervosa. Archives of General Psychiatry, 37, 1030-1035.

Garfinkel, P. E. (1981). Some recent observations on the pathogenesis of anorexia nervosa. Canadian Journal of Psychiatry, 26, 218-223.

Garfinkel, P. E., & Garner, D. M. (1982). Anorexia nervosa: A multidimensional perspective. New York: Brunner/Mazel.

Garfinkel, P. E., Moldofsky, M. D., & Garner, D. M. (1980). The heterogeneity of anorexia nervosa. Archives of General Psychiatry, 37, 1036-1040.

Garner, D. M., & Garfinkel, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. Psychological Medicine, 9, 273-279.

Halmi, K. A., Falk, J. R., & Schwartz, E. (1981). Binge-eating and vomiting: A survey of a college population. Psychological Medicine, 11, 697-706.